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AREA

Sample Claim for Health Dept. Providers:  
Billing for Immunization Administration Fee

# HEALTH INSURANCE CLAIM FORM

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>9000000000</b>									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Woods, Tiger</b>										3. PATIENT'S BIRTH DATE MM DD YY <b>01 16 1996</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) <b>22 Master's Lane</b>										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY <b>Raleigh</b>										8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>									
STATE <b>NC</b>										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO									
ZIP CODE <b>27606</b>										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME									
TELEPHONE (Include Area Code) <b>(919) 222-2222</b>										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____									
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) DD YY <b>03 17 2000</b>										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY <b>03 17 2000</b>									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <b>1. V06.1</b>										17a. I.D. NUMBER OF REFERRING PHYSICIAN <b>3. 1</b>									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) <b>1. V06.1</b>										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER									
24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE MM DD YY MM DD YY CPT/HCPCS MODIFIER 1. 03 17 2000 03 17 2000 11 01 W8012 27.42 2 2. 03 17 2000 03 17 2000 11 01 90701 X5 0.00 1 3. 03 17 2000 03 17 2000 11 01 90712 X4 0.00 1 4. 03 17 2000 03 17 2000 11 01 90718 X2 0.00 1																			
25. FEDERAL TAX I.D. NUMBER SSN EIN <b>32144</b>										26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO									
28. TOTAL CHARGE <b>\$ 27.42</b>										29. AMOUNT PAID <b>\$ 27.42</b>									
30. BALANCE DUE <b>\$ 27.42</b>										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>Signature on file 4/4/00</b>									
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) <b>Masters County Health Dept. 124 Hole In One Court Masters, NC 20000</b>										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>Masters County Health Dept. 124 Hole In One Court Masters, NC 20000</b>									
SIGNED _____ DATE _____										PIN# <b>9965432</b> GRP# <b>3404000</b>									